		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038893

Facility Name: Center Home for Hispanic Elderly

Address: 1401 N. California (Number) Chicago (City) 60622 (Zip Code)

County: Cook

Telephone Number: 773-7828700 **Fax #** 773-2760465

IDPA ID Number: 36-3527934001

Date of Initial License for Current Owners: 02/18/82

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 C(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Dan Malone **Telephone Number:** 708-7102151

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Catalina Soto
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Daniel L. Malone
(Firm Name & Address) DLM Financial Advisory Services, 133 S. Old Creek Rd. Palos Park, IL. 60464
(Telephone) 708-7102151 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: June 30,2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,641	426		12,067	8
9	SNF/PED					9
10	ICF	38,220	426		38,646	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,861	852		50,713	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.06%

D. How many bed-hold days during this year were paid by Public Aid?
1,654 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 02/18/82

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: June 30,2003 Fiscal Year: June 30,2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: June 30,2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	296,999	44,237	22,455	363,691		363,691		363,691			1
2	Food Purchase		231,936		231,936		231,936		231,936			2
3	Housekeeping	38,804	23,000		61,804		61,804		61,804			3
4	Laundry	88,939	47,101		136,040		136,040		136,040			4
5	Heat and Other Utilities			121,854	121,854		121,854		121,854			5
6	Maintenance	112,189	9,186	62,003	183,378		183,378	161,061	344,439			6
7	Other (specify):* Equipment Rental			30,487	30,487		30,487		30,487			7
8	**TOTAL General Services**	536,931	355,460	236,799	1,129,190		1,129,190	161,061	1,290,251			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,226,581	142,109	85,117	2,453,807		2,453,807		2,453,807			10
10a	Therapy	36,844			36,844		36,844		36,844			10a
11	Activities	89,063		2,101	91,164		91,164		91,164			11
12	Social Services	61,936		1,475	63,411		63,411		63,411			12
13	Nurse Aide Training	11,667			11,667		11,667		11,667			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,426,091	142,109	88,693	2,656,893		2,656,893		2,656,893			16
	C. General Administration											
17	Administrative	234,872		408,360	643,232		643,232	(375,691)	267,541			17
18	Directors Fees											18
19	Professional Services			32,909	32,909		32,909	13,089	45,998			19
20	Dues, Fees, Subscriptions & Promotions			18,977	18,977		18,977		18,977			20
21	Clerical & General Office Expenses	192,202	16,131	76,290	284,623		284,623	233,034	517,657			21
22	Employee Benefits & Payroll Taxes			737,773	737,773		737,773	36,825	774,598			22
23	Inservice Training & Education							173	173			23
24	Travel and Seminar							2,296	2,296			24
25	Other Admin. Staff Transportation			13,472	13,472		13,472		13,472			25
26	Insurance-Prop.Liab.Malpractice			66,355	66,355		66,355		66,355			26
27	Other (specify):* Bad Debts			181,274	181,274		181,274	(181,274)				27
28	**TOTAL General Administration**	427,074	16,131	1,535,410	1,978,615		1,978,615	(271,547)	1,707,068			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,390,096	513,700	1,860,902	5,764,698		5,764,698	(110,485)	5,654,213			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Center Home for Hispanic Elderly #0038893 Report Period Beginning: 1-Jul-02 Ending: 30-Jun-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			137,473	137,473		137,473	120,310	257,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,175	55,175		55,175	(743)	54,432			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			192,648	192,648		192,648	119,567	312,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,112	86,112		86,112		86,112			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			86,112	86,112		86,112		86,112			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,390,096	513,700	2,139,662	6,043,458		6,043,458	9,081	6,052,539			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: ######

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(743)	P4L 31		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,678)	P3L19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(181,274)	P3L17		24
25	Fund Raising, Advertising and Promotional	(8,685)	P3L21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Refer to page 5A	(29,048)	P3L21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (221,428)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	270,627		34
35	Other- Attach Schedule **CEO allocation**	(40,118)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 230,509		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 9,081		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ Only for Public Aid		38
39				Pending Patients		39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Center Home for Hispanic Elderly

ID# 0038893

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Equipment Rental from Related Organization	$		1
2	Padres Corporation	29,048	Line 21	2
3	(Actual Cost included in the allocation of			3
4	indirect expenses page 7 of this report)			4
5	Marketing Personnel	8,685	Line 21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	37,733		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 **Report Period Beginning:** 1-Jul-02 **Ending:** 30-Jun-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Center Home for Hispanic Elderly **#** 0038893 **Report Period Beginning:** 1-Jul-02 **Ending:** 30-Jun-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Other Administrative Expense	$ 408,360	Padres Corporation		$ 678,987	$ 270,627	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 408,360			$ 678,987	$ * 270,627	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 30-Jun-03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None	None	None						$		1
2											2
3	Please refer to page 8										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Casa Central Padres Corporation
Street Address: 1343 N. California Ave.
City / State / Zip Code: Chicago , IL 60622
Phone Number: (773-6452300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Please refer to page 24 for details	Total Operating	2	2	$ 2,335,651	$ 1,005,179		$ 678,987	1
2			costs for each entity							2
3	Line 6	Salaries - Maintenance	Salaries are allocated to Page 3, Line 17 and Line 21. The executive director's salary is reported on line 17 column 1 in the amount of $4						71,306	3
4	Line 17	Salaries - Administrative							72,787	4
5	Line 21	Salaries- Clerical							208,947	5
6	Line 22	Fringe Benefits							48,406	6
7	Line 22	Payroll Taxes							17,467	7
8	Line 19	Professional and Contractual Services							14,767	8
9	Line 21	Supplies							14,162	9
10	Line 6	Occupancy							85,420	10
11	Line 21	Telephone							8,379	11
12	Line 21	Postage							2,159	12
13	Line 6	Equipment Rental and Maintenance							4,336	13
14	Line 25	Transportation							2,296	14
15	Line 23	Conferences, convention and meetings							173	15
16	Line 21	Miscellaneous							8,073	16
17	Line 31	Depreciation							120,310	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,335,651	$ 1,005,179		$ 678,987	25

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Line 19	Computer Services				$	$		$	1
2	Line 24	Travel and Seminar								2
3	Line 22	Employee Want Ads								3
4	Line 30	Depreciation								4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 30-Jun-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank One			Building Mortgage			$ 307,831	$ 280,406		4.2500	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank One			Line of Credit			925,000	980,000		Variable		6
7	Washington Square			Working Capital			100,047	68,311		5.0000		7
8												8
9	TOTAL Facility Related						$ 1,332,878	$ 1,328,717			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,332,878	$ 1,328,717			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Center Home for Hispanic Elderly **#** 0038893 **Report Period Beginning:** 1-Jul-02 **Ending:** 30-Jun-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	Not Applicable	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	Not Applicable	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	Not Applicable	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	Not Applicable	8
1999	Not Applicable	9
2000	Not Applicable	10
2001	Not Applicable	11
2002	Not Applicable	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Center Home for Hispanic Elderly COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038893

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Not Applicable	Not Applicable	$ Not Applicable	$ Not Applicable
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 30-Jun-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,149 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	55,145	1981	$ 45,000	1
2					2
3	TOTALS	55,145		$ 45,000	3

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: June 30,2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	149		1981		$ 255,000	$ 10,200	25	$ 10,200	$	$ 219,300	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1982	2,251	90	25	90		1,935	9
10	Fire sprinkler, Windows and othe items			1983	205,573	8,223	25	8,223		168,569	10
11	Fire alarms, Wheelchair ramp & Other items			1985	41,435	1,657	25	1,657		31,461	11
12	Elevator, Nurse's station & Rear stairway			1986	236,110	9,444	25	9,444		165,276	12
13	Door,Carpeting and air conditioning lines			1988	1,153	46	25	46		715	13
14	New roof and tuckpointing			1990	38,398	2,560	15	2,560		33,279	14
15	Heating, fire alarms and other items			1984	72,587	2,904	25	2,904		56,619	15
16	Elevator repair and tuckpointing			1992	10,325	688	15	688		7,628	16
17	Elevator repair and tuckpointing			1993	67,891	4,527	15	4,527		46,371	17
18	Improvements			1994	44,641	2,976	15	2,976		28,592	18
19	Elevator repair and roof repairs			1995	42,324	2,822	15	2,822		24,720	19
20	Front door			1995	11,843	789	15	789		6,901	20
21	Electircal Improvements			1995	213,730	14,289	15	14,289		128,318	21
22	Boiler repairs			1995	15,681	1,045	15	1,045		8,826	22
23	Water heater			1995	2,025	135	15	135		1,204	23
24	Plumbing repairs			1995	1,550	103	15	103		895	24
25	Laundry and kitchen repairs			1996	10,500	700	15	700		5,486	25
26	4 th floor construction			1996	10,300	687	15	687		5,298	26
27	Boiler repairs			1996	2,180	145	15	145		1,138	27
28	Electric upgrade			1996	895	60	15	60		438	28
29	Kitchen repairs			1997	4,200	280	15	280		1,851	29
30	Elevator repairs			1997	23,440	1,563	15	1,563		4,166	30
31	Electrical repairs			1997	6,985	466	15	466		3,069	31
32	Install new doors			1997	1,675	112	15	112		699	32
33	Boiler repairs			1997	3,573	238	15	238		1,488	33
34	Rewire kitchen and sump pumps			1991	41,225	2,748	15	2,748		32,981	34
35	Airconditioning lines			1989	2,696	108	15	108		1,564	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 30-Jun-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bathroom remodeling	1998	$ 96,661	$ 6,444	15	$ 6,444	$	$ 35,343	37
38	Elevator repair	1998	3,000	200	15	200		1,083	38
39	Laundry pumps	1998	4,422	294	15	294		1,583	39
40	Electrical work	1998	31,052	2,070	15	2,070		10,740	40
41	Airconditioner	1998	933	62	15	62		326	41
42	Kitchen work	1998	3,903	260	15	260		1,322	42
43	Boiler repairs	1998	1,875	125	15	125		635	43
44	Dampers	1998	6,220	415	15	415		2,109	44
45	Doors and frames	1998	20,263	1,350	15	1,350		3,801	45
46	Building Improvements: Electical transfer switches	1999	9,591	639	15	639		3,090	46
47	Kitchen fire extinquishing system	1999	1,500	100	15	100		483	47
48	Toaster wiring	1999	1,370	91	15	91		426	48
49	Baseboard radiators	1999	1,000	67	15	67		301	49
50	Baseboard radiators	1999	800	53	15	53		239	50
51	Electrical transfer switches	1999	3,599	233	15	233		1,010	51
52	Access Panels	1999	3,125	208	15	208		902	52
53	Access Panels	1999	1,025	68	15	68		284	53
54	Fire dampers	1999	1,550	103	15	103		429	54
55	Roof repairs	1999	1,000	67	15	67		278	55
56	Roof repairs	1999	1,000	67	15	67		278	56
57	Water heater	1999	3,490	233	15	233		931	57
58	Electrical repairs	1999	2,443	162	15	162		650	58
59	Exit signs	1999	1,089	73	15	73		279	59
60	Water heaters	1999	1,490	99	15	99		347	60
61	Metal fencing	1999	1,000	67	15	67		267	61
62	Metal fencing	1999	800	53	15	53		212	62
63	Replace Handrails	1999	26,000	1,733	15	1,733		5,777	63
64	Upgrade telephone system	1999	3,772	251	15	251		837	64
65	Boiler and gas line replacement and repairs	1999	3,990	266	15	266		1,064	65
66	Emergency system upgrade	1999	3,440	229	15	229		916	66
67	Boiler repairs	1999	2,977	198	15	198		892	67
68	Dairy compressor and stairway lights	2000	7,204	480	15	480		1,805	68
69	Computer wiring	2000	4,958	330	15	330		1,366	69
70	TOTAL (lines 4 thru 69)		$ 1,626,728	$ 86,695		$ 86,695	$	$ 1,068,792	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,626,728	$ 86,695		$ 86,695	$	$ 1,068,792	1
2	Water heater	2000	6,980	465	15	465		1,589	2
3	Floor tile	2000	258	16	15	16		108	3
4	Kitchen rehab	2000	4,286	348	15	348		1,680	4
5	Handrails	2000	13,500	900	15	900		2,925	5
6	Roof repairs	2000	27,600	1,840	15	1,840		5,980	6
7	Emergency generator	2000	64,267	4,284	15	4,284		13,566	7
8	Roof repairs	2000	28,000	1,867	15	1,867		5,757	8
9	Sump pumps	2001	4,750	316	15	316		897	9
10	Alarm system	2001	2,776	185	15	185		509	10
11	Handrails	2001	12,132	809	15	809		2,157	11
12	Windows	2001	2,300	153	15	153		345	12
13	Water tank	2001	5,452	363	15	363		909	13
14	Tank removal	2001	9,510	634	15	634		1,475	14
15	Windows	2001	3,560	237	15	237		633	15
16	Tuckpointing	2001	900	60	15	60		130	16
17	Handrails and architectural fees	2001	5,163	344	15	344		717	17
18	Electrical wiring	2001	1,153	77	15	77		160	18
19	Disposal valve	2001	400	27	15	27		56	19
20	Emergency generator install wiring	2001	550	37	15	37		76	20
21	Boiler	2001	4,429	295	15	295		615	21
22	Floor tile	2001	512	34	15	34		71	22
23	Selector unit for building elevator	2001	5,200	347	15	347		722	23
24	Generator and tank removal	2001	4,000	267	15	267		644	24
25	Sewerage pump	2001	7,348		15			1	25
26	Alarm system	2001	4,470	298	15	298		795	26
27									27
28	Roof repairs	2001	1,927	128	15	128		257	28
29	Kitchen plumbing	2001	1,500	100	15	100		158	29
30	Fire rated door	2002	1,800	120	15	120		180	30
31	Elevator repairs	2001	21,440	1,429	15	1,429		2,739	31
32	Boiler repairs	2001	3,313	221	15	221		387	32
33	New boiler	2002	3,000	220	15	220		312	33
34	TOTAL (lines 1 thru 33)		$ 1,879,204	$ 103,117		$ 103,117	$	$ 1,115,342	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: July 1,2002 Ending: 30-Jun-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,879,204	$ 103,117		$ 103,117	$	$ 1,115,342	1
2	Elevator Repair	2002	10,000	667	15	667		1,556	2
3	Fire alarms and exit signs	2002	7,208	481	15	481		1,122	3
4	Electrical work laundry	2002	1,839	123	15	123		286	4
5	Building elevator repair	2002	1,340	89	15	89		201	5
6	New elevator motor	2003	15,000	1,000	15	1,000		1,000	6
7	Doors	2003	59,850	2,608	15	2,608		2,608	7
8	Architectual fees for improvements	2003	4,500	275	15	275		275	8
9	Grease trap and boiler	2003	7,585	289	15	289		289	9
10	Tuckpointing	2003	6,800	283	15	283		283	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,993,326	$ 108,932		$ 108,932	$	$ 1,122,962	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,993,326	$ 108,932		$ 108,932	$	$ 1,122,962	1
2	Total Cost of Assets from Padres Corporation		1,010,937						2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,004,263	$ 108,932		$ 108,932	$	$ 1,122,962	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 30-Jun-03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 186,827	$ 26,420	$ 26,420	$		$ 114,280	71
72	Current Year Purchases	20,210	1,375	1,375			1,375	72
73	Fully Depreciated Assets	216,965					216,965	73
74								74
75	TOTALS	$ 424,002	$ 27,795	$ 27,795	$		$ 332,620	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,473,265	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 136,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 136,727	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,455,582	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	None	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 8,500	92
93			93
94			94
95		$ 8,500	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	None		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-03 Ending: 30-Jun-03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 30-Jun-03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 21,563	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	894,213		3
4	Supply Inventory (priced at)	28,346		4
5	Short-Term Investments			5
6	Prepaid Insurance	158,327		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	37,767		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,140,216	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	45,000		13
14	Buildings, at Historical Cost	255,000		14
15	Leasehold Improvements, at Historical Cost	1,738,529		15
16	Equipment, at Historical Cost	424,002		16
17	Accumulated Depreciation (book methods)	(1,455,582)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Constuc in Progress**	8,500		22
23	Other(specify): **Mortgage costs**	42		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,015,491	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,155,707	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 200,601	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,573		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Line of Credit**	980,000		36
37	**Padres Corporation**	124,929		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,499,103	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	346,373		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 346,373	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,845,476	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 310,231	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,155,707	$	48

***(See instructions.)**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/02 Ending: 6/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 815,335	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 815,335	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(495,782)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Other charges to fund balance.**	(9,322)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (505,104)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 310,231	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/02 Ending: 06/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,258,098	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,258,098	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	288,835	24
25	Interest and Other Investment Income***	743	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 289,578	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,547,676	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,129,190	31
32	Health Care	2,656,893	32
33	General Administration	1,978,615	33
	B. Capital Expense		
34	Ownership	192,648	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	86,112	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,043,458	40
41	**Income before Income Taxes (line 30 minus line 40)****	(495,782)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (495,782)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 7/1/2002 Ending: 06/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,728	2,080	$ 70,815	$ 34.05	1
2	Assistant Director of Nursing	1,243	1,405	49,067	34.92	2
3	Registered Nurses	17,978	18,900	607,505	32.14	3
4	Licensed Practical Nurses	19,184	21,826	424,757	19.46	4
5	Nurse Aides & Orderlies	84,886	97,618	923,369	9.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,309	12,195	148,158	12.15	8
9	Activity Director	1,808	1,920	23,567	12.27	9
10	Activity Assistants	9,163	10,102	65,496	6.48	10
11	Social Service Workers			61,936		11
12	Dietician					12
13	Food Service Supervisor	1,448	1,700	57,835	34.02	13
14	Head Cook	4,217	5,047	48,182	9.55	14
15	Cook Helpers/Assistants	11,224	12,381	115,504	9.33	15
16	Dishwashers	10,463	11,716	75,478	6.44	16
17	Maintenance Workers	9,253	10,482	112,189	10.70	17
18	Housekeepers	6,072	6,511	38,804	5.96	18
19	Laundry	10,261	11,660	88,939	7.63	19
20	Administrator	1,576	2,080	113,827	54.72	20
21	Assistant Administrator	1,756	2,080	80,927	38.91	21
22	Other Administrative	1,589	1,965	17,695	9.01	22
23	Office Manager					23
24	Clerical	16,202	17,740	176,782	9.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,389	4,144	49,146	11.86	31
32	Other Health Care(specify)					32
33	Other(specify) President	667	695	40,118	57.72	33
34	TOTAL (lines 1 - 33)	223,416	254,247	$ 3,390,096 *	$ 13.33	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,075	line 1 col. 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant		2,213	line 10 col. 3	38
39	Pharmacist Consultant		338	line 10 col. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,475	line 11 col. 3	45
46	Other(specify)				46
47	Unemployment Tax Consultant		525	line 21 col. 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 12,626		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,898	$ 63,785		50
51	Licensed Practical Nurses	520	18,227		51
52	Nurse Aides	16	296		52
53	TOTAL (lines 50 - 52)	2,434	$ 82,308		53

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-03 Ending: 30-Jun-03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gilbert Torres	Administrator	none	$ 113,827
Catalina Soto	Assistant Administrator	none	80,927
Ann Alvarez	President	none	40,118
(This CEO salary was adjusted out of the cost report.)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 234,872

B. Administrative - Other

Description		Amount
Padres Corporation	Provide general oversite and direction.	$ 408,360
TOTAL (agree to Schedule V, line 17, col. 3)		$ 408,360
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
Harris Kessler & Goldstein LLC	Legal	$ 1,440
Scott & Kraus LLC	Legal	1,273
Dimonte & Lizak	Legal	1,678
DLM Financial Advisory Services	Accounting	11,735
PTW	Accounting	15,338
Micheal Anderson	Accounting	560
Personel Planners	Unemployment	885
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,909

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 299,815
Unemployment Compensation Insurance	9,143
FICA Taxes	248,487
Employee Health Insurance	165,834
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	4,119
Disability Insurance	5,783
Employee Recognition Awards	2,448
Employee Physicals	2,144
TOTAL (agree to Schedule V, line 22, col.8)	$ 737,773

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Training and Education	735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 735

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 1-Jul-02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ _____
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? _____ If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **No**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **FPT & W Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? _____

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? _____
Attach invoices and a summary of services for all architect and appraisal fees.

Center Home for Hispanic Elderly
Allocation of Indirect Costs to Center Home
Padres Corporation
General and Administrative Services
Fiscal Year End: June 30, 2003

Description	Original Amount	Adjustments	Adjusted Total	Amount Allocated To Center Ho
Salaries of Padres:	1,210,154		1,210,154	
Less Salaries Not Associated With Services Provided to Center Home		(305,015)		
Community Relations, ITS, Development, Accounting				
Total Adjustment				
Net Salaries to Allocate:	1,210,154	(305,015)	905,139	317,904
Administration Includes the combined CEO salary from allocati		123,657	207,241	72,787
Clerical			594,916	208,947
Maintenance			203,022	71,306
Total Salaries			1,005,179	353,040
Fringe Benefits	256,771	64,718	192,053	48,406
Payroll Taxes	92,653	23,353	69,300	17,467
			-	65,873
Other Expenses			-	
Professional and Contractual Services	56,215	14,169	42,046	14,767
Supplies	53,910	13,588	40,322	14,162
Occupancy	325,166	81,957	243,209	85,420
Telephone	31,895	8,039	23,856	8,379
Postage	8,217	2,071	6,146	2,159
Equipment Rental and Maintenance	16,505	4,160	12,345	4,336
Transportation	8,742	2,203	6,539	2,296
Conferences, convention and meetings	659	166	493	173
Grants	200,000	200,000	-	-
Miscellaneous	30,730	7,745	22,985	8,073
Depreciation	457,979	115,432	342,547	120,310
Total	1,190,018		740,487	260,075
Total of All Expenses	2,749,596		2,211,994	678,987

Allocation Basis:	**Total Costs**	**Percentage of Total Costs**
Center Home for Hispanic Elderly	6,043,458	**35.12%**
Casa Central Social Services Corp.	11,163,554	**64.88%**
Total	**17,207,012**	**100.00%**

Adjustment Basis For Non Salary Costs	**Total Costs**	**Percentage of Total Costs**
Total Non Care Related Salaries	305,015	**25.20%**
Total Salaries	1,210,154	

Allocation of Fixed Asset Costs	
Total Costs	4,010,917
Allocation Percentage	25.20%
Total of Allocated Costs	1,010,937
Amount Allocated to Building Costs Schedule XI B	1,010,937